THE SOCIETY OF THE NEW YORK HOSPITAL

RECORD

SEPTEMBER, 1956

the rheumatic cardiac clinic

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NEW YORK CITY'S FIRST VOLUNTARY, NON-PROFIT HOSPITAL
1771 - 1956

The New York Hospital is not privately owned. Nor is it City-owned. It is a voluntary Hospital. It was established under a charter granted in 1771, as a community Hospital — a voluntary, non-profit organization that belongs to you and to all the others who use its services. It is dedicated to the care of the sick and has faithfully served all who have turned to it for help — over 4,000,000 people during 185 years.

You help yourself, your family, your neighbor,
when you help YOUR Hospital

charter day

Lieutenant General James M. Gavin, GS, Chief of Research and Development, United States Army, and Harold G. Wolff, M. D., Attending Physician in Medicine and Attending Psychiatrist at The New York Hospital and Professor of Medicine (Neurology) at Cornell University Medical College, were the speakers at ceremonies Tuesday, May 8, 1956, marking the 185th anniversary of the granting of a Charter to The Society of the New York Hospital. The meeting, with Hamilton Hadley, President of the Board of Governors of The Society of the New York Hospital, presiding, was held in the Nurses' Residence.

General Gavin talked on the Army's Research and Development Program with the aim of familiarizing the audience with the philosophy upon which the program is based. He elaborated on our need for armed forces and the role they should fulfill if they are to serve the national interests; and spoke of technical trends such as atomic weapons, missiles and air vehicles which will "add flexibility to our foreign policy, be reassuring to the Western World, and guarantee our survival."

General Gavin also commented on The New York Hospital's long and continuous association with the U. S. Army, our representatives having shared the combat hazards and the responsibilities of the care of soldiers since the beginning of our country.

"Has Disease Meaning?" was the topic of Dr. Wolff's speech. He talked of a relatively new concept of disease which stems in good part from work at The New York Hospital. Dr. Wolff's speech is reproduced in its entirety elsewhere in The Record.

At the conclusion of the Charter Day program, a reception and tea were held for members and friends of The Society of the New York Hospital.

Attending the Charter Day exercises — L. to R.: Dr. Henry N. Pratt, Dr. Harold G. Wolff, Mr. Hamilton Hadley, Lieutenant General James M. Gavin, Mr. John Hay Whitney and Dr. Joseph C. Hinsey.

On arrival, the patient and the relatives are received by the admitting psychiatrist.

A BRIEF LOOK AT THE

westchester division

In 1821 when The Society of the New York Hospital established its first psychiatric division in a building separate from the general hospital, emphasis was placed on the "safe custody and humane care" of the patient. For that time, this constituted one of the best and in fact most elaborate means of treatment and rehabilitation, though decidedly elementary as compared with present standards. Today, with the use of intensive psychotherapy and program activities such as physiotherapy, physical education, occupational therapy, social occasions, books, music and others, more than eighty percent of patients are each year restored to the community, often better able than before to pursue their lives comfortably and productively. Not all are permanently or fully recovered, but certainly the percentage showing definite improvement keeps increasing and the period of hospitalization is often reduced. This advance has been brought about by the development of the science of psychiatry as a branch of medicine. In the course of this development, new ways of reaching and guiding the sick mind, namely therapies, have been evolved.

The word therapy, in its broadest sense, means simply the curing of disease. The New York Hospital-Westchester Division is therefore preeminently a therapeutic community, for its major purpose is the day by day treatment of

patients suffering from acute and recoverable psychiatric disorders. A steadfast dedication to this objective has resulted in the constant enrichment of the program which today comprises many divers treatment aids and program therapies as noted above.

Without question the core of psychiatric treatment as it is practiced in this hospital is psychotherapy. There is no substitute for the skillful psychiatric interview, though numerous other treatment forms are used in conjunction with this, and are complementary to it. These can be generally classified in two categories, first the program therapies and second, treatment aids which are prescribed for and administered to the patient or which constitute the hospital environment, affecting him constantly but unobtrusively.

The department of physiotherapy is perhaps a good illustration of therapy which combines both direct and more subtle benefits. The patient is introduced to this department as early as possible for reasons that are not only physical but also psychological. New patients are lonely, often somewhat demoralized and usually ill at ease. Not yet prepared to adjust to the group or even to the regime, they crave the security of personal attention. This is supplied by the expert physiotherapist. The various baths, massage, ultra violet rays and other treatments are relaxing and soothing in themselves, but even more important is the reassurance given by this evidence of concern for the patient's well being. Someone, namely the therapist, is tending to his comfort, without judging him or criticizing him or making him feel guilty or under strain. This is empathy in practical form. The comfortable and attractively appointed rooms, painted in soft pastel tones enhance the impression of friendliness. This is not, of course, restricted to the early days of hospitalization but it is especially valuable at that period.

To carry this point a step further one might comment briefly on the reasons, apart from the obvious ones, why the hospital buildings and grounds are maintained with such scrupulous care. Even for the patient who may seem at first, or during certain phases of his or her illness to be largely impervious to esthetic impressions, the maintenance of high standards in the preparation and serving of food, in housekeeping details and in the care of gardens, trees and grounds is a strong factor in rebuilding dignity and self respect which a severe mental illness has damaged. The setting, however pleasing, is not in itself the cure, but it plays an important part in making the patient receptive to psychotherapy and to other aspects of a full treatment program.

Still another treatment procedure leading to rehabilitation should be mentioned in view of the experiments in day care which are currently being instituted in various psychiatric centers. To ease the abrupt transition between hospitalization and the normal life of home, school or occupation, many convalescent patients in the Westchester Division commute to home, college or office over a period of weeks or even months, but spend their nights and most weekends at the hospital. Proximity to the metropolis makes this possible. As the patient becomes more firmly established in his rehabilitation, he finds himself once more able and ready to assume his accustomed role in the community.

Patients at the Westchester Division are never photographed — Hospital personnel substitute for patients.

patient care

IS A COORDINATED EFFORT

A NEW concept of nursing "Total Patient Care" has been developed at The New York Hospital. This concept combines a knowledge not only of the patient's illness but also of his background, his home and his family.

Once a day, after the patients have been fed, bathed and given their medications, staff members who comprise nursing teams meet to discuss the patients in their unit, and to evaluate their nursing care plan for the next twenty-four hours.

In advance of the group conference, the team leader talks with the head nurse who assigns new patients from expected admissions and relays staff doctor's orders. The head nurse is responsible for dividing her staff into nursing teams and assigning a leader to each team.

A graduate nurse as team leader first identifies the problems and then interprets these to her team co-workers. She directs her team, delegating specific responsibilities and evaluating and reporting the results of the care given by her team.

A team may consist of another graduate nurse, a student nurse, nursing aides—men or women—and occasionally a practical nurse. The makeup of the team depends on availability of personnel, the size of the unit and the kinds of illnesses which the patients have. Student nurses function as team members throughout their nursing preparation. Nursing aides are trained "on the job" by hospital staff education instructors. In the classroom aides learn to make beds, bathe patients, take temperatures and perform the nursing functions that will be assigned to them as team members. On the floor and in conference they learn another aspect of patient care—patient relations. While the aide is learning, the team leader supervises her directly until proficiency is assured.

During each team conference, the leader, using information taken from the individual hospital record, directs discussion of each patient. The day's plan for the patient is outlined and any new treatment or medication is explained. Questions are expected and suggestions sought. This is an opportunity for each team member to offer her observations and to report the questions or objections raised by each patient. Even the fact that a patient says nothing is noted and evaluated. Silence often signals worry or fear.

An example of this coordinated effort is Mr. W., a diabetic who is to be discharged later in the week. He seems to lack self-confidence. Does he feel his family does not want him home? Perhaps his family fears he will be too difficult to care for. These suggestions come from different team members—(1) from the graduate nurse or student nurse who has been teaching him to give himself insulin, or (2) from the nursing aide who has come to know him as she makes his bed, takes his temperature and serves his meals.

The team leader offers suggestions and makes a note to discuss this situation

(Continued on page 17)

Mothers look to the hospitol nurse for o speciol type of guidonce os directed by Attending Pediotricions, or to corry out instructions which will help them to give the best of core to their children.

the rheumatic cardiac clinic

The Rheumatic Cardiac Clinic at The New York Hospital had its beginning in 1916 in the Cornell Pediatric Out-Patient Department situated at 28th Street and First Avenue, New York City. Cardiac patients were cared for there under the supervision of Dr. May G. Wilson until 1920 when this service was discontinued and all registered cardiac patients were transferred to the New York Nursery and Child's Hospital, under the continued supervision of Dr. Wilson.

It was at the New York Nursery and Child's Hospital that the first formal Cardiac Clinic was established as an official member clinic of the New York Heart Association. When The New York Hospital-Cornell Medical Center was formed in

Miss Rose Johnstone, sociol worker, hos been ossocioted with the clinic since 1928 ond her close contoct with the fomilies hos mode this long term follow-up possible.

Sociol worker, doctor, hospitol nurse, public heolth nurse ond other specialists oll pool their knowledge with one oim— comprehensive core of the potient.

1932, the New York Nursery and Child's Hospital became the Pediatric Division of the Center. Dr. Samuel Z. Levine, Pediatrician-in-chief, and provided both in-patient and out-patient services. Thus the cardiac patients who originally registered at the Cornell Out-Patient Department (1916-1920) and were transferred to the clinic at Nursery and Child's Hospital, continue to receive treatment at The New York Hospital's Rheumatic Cardiac Clinic under the supervision of Dr. Wilson.

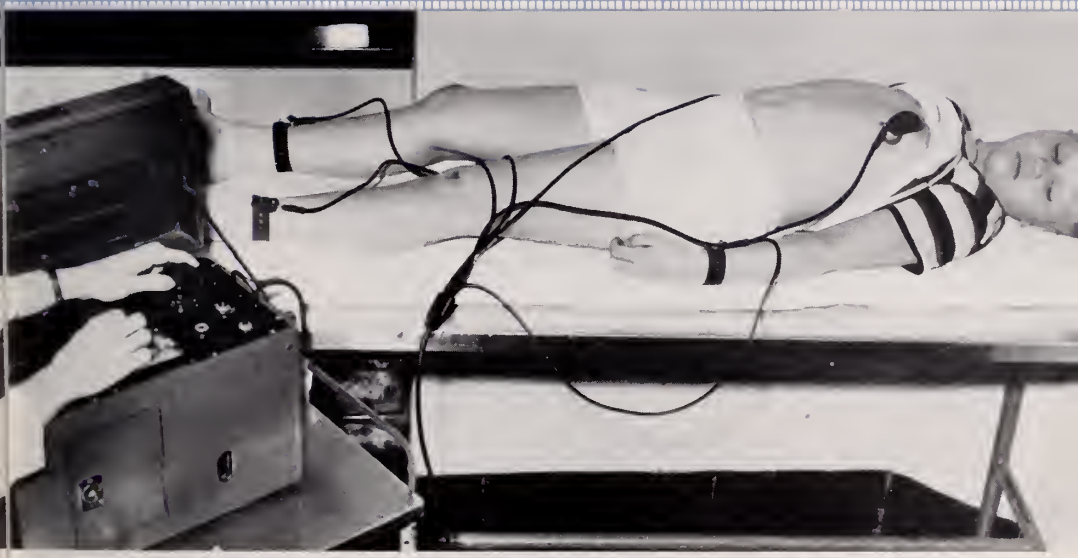
This Clinic is a diagnostic, treatment and research clinic. It serves as a consultation clinic for the Pediatric Out-Patient Department and referring physicians, and provides continuous medical care throughout adolescence and adult life for registered patients. Each year some 1500 rheumatic heart patients (800 reached 20-52 years) are cared for in addition to the 800 children of these patients who are under medical supervision for the study of the role of heredity in rheumatic heart disease.

Through the interest and generous support of the Commonwealth Fund and The Helen Hay Whitney Foundation the completion of a forty-year follow-up of patients with rheumatic heart disease will be marked at the close of 1956. This is the longest follow-up of patients that anyone has so far attempted. The study will provide longitudinal data on life expectancy for patients with rheumatic heart disease and will provide information on the influence of current therapy on the natural history of rheumatic heart disease.

PAUL PARKER

Test far vital capacity (shown above) is recorded on each check-up visit. This measurement provides o guide of exercise talerance.

Continuous medical care for registered rheumatic heart patients, includes routine monthly visits to the Clinic, home visits when necessary and telephone contact at all times.



An electrocardiogram is taken during the first examination and is repeated as necessary.

Particularly important far the early diognosis of cordioc involvement ore fluoroscopic examinations of the heart. These examinations in frontal ond oblique views at specific degrees af rototion, indicate abnormolity of the individual chambers and afford opportunities for detectian of slight degrees af heart enlargement.

Susy, age 10, injured outside her home, was admitted to the hospital on March 8, 1956 with acute rheumatic corditis. She received one week of harmone therapy, recavered without recurrence ar complicotions ond was discharged from the haspital on March 16, 1956 in gaad condition. She was able ta be up and abaut and returned ta school within three weeks after her return hame.

The majority af children receiving early, odequate hormone therapy have shart hospitalizotian and convalescence periads.

Until recently rheumotic children spent long periads af inactivity fallawing on attack af rheumatic fever.

Each of the abave children had an attack of rheumatic fever and received harmone therapy. After discharge fram the hospital, they returned hame and were encouraged ta enjay all narmal activities except campetitive sparts.

Care of the Rheumotic Family. This patient, mother of three children, has been attending the rheumatic cardiac clinic at The New York Hospital, since her first attack of rheumatic corditis twenty-two yeors ago. Her children do not have rheumatic fever, but general pediatric care is provided at this clinic for the children of parents with rheumatic heort disease.

has disease meaning?

Harold G. Wolff, M.D.

To many of my energetic and creative friends this question: "Has disease meaning?" seems fatuous and woolly. Mindful of the hard won battle necessary to establish the experimental method and attitude in Medicine, they are loath to recognize questions about meanings and goals. Indeed, from the middle of the nineteenth century until recently, the study of parts and elements has been pursued so intensively and, incidentally, so successfully as almost entirely to consume the energies and interest of creative minds. Thus, the study of Man in the context of his environment was considered an unsuitable subject for Science. Attempts to gain a more inclusive view were not compatible with that period's genius. It is evident that each period has its own particular insight and preferred kinds of knowledge. The history of thought has been characterized by swings in interest from the whole to the part and then to the whole again.

As a matter of fact, antedating the lively interest in part phenomena cited above, Claude Bernard, the great French biologist of the early nineteenth century, asked the question of this essay. He saw disease as the outcome of attempts at adaptation to noxious forces. These responses, though appropriate in kind, he saw to be faulty in amount. He suggested that the adaptive response, in its intensity, could be more destructive than the original assaults, and that an individual might be damaged gravely through the wrong magnitude of his defensive reaction. For instance, the presence of micro-organisms in the lung evokes cellular and humoral responses that serve to meet invasion and do so effectively. Yet the magnitude of the responses may lead to congestion of the lungs and pneumonia. The provocative effect of the scope and simplicity of this thesis cannot be overestimated.

However, Claude Bernard's emphasis upon experiment initiated the swing toward intense preoccupation with the kind of questions which designed experiments can answer: and hence the growth during the next period of the study of part-phenomena.

With the unfolding of the Twentieth Century, the need for unifying knowledge and for the study of relationships between parts, again was voiced in many areas of thought and effort. In medicine during the Century's first quarter there was a reaction against extreme partitioning of inquiry. It was J. S. Haldane, the distinguished British physiologist in his now classic monograph on respiration who said "Since the time of Hippocrates, the growth of scientific medicine . . . has been based on the study of the manner in which . . . the human body expresses itself in response to change in environment, and that only through the study of it can we recognize and interpret disturbances of health."

At Harvard, Walter B. Cannon profoundly influenced thinking by offering a unifying theory concerning the body's drive to maintain internal stability. In

other than biologic fields, the contemporary imagination's appetite for unity was being strikingly shown in the major styles in the plastic arts, in the physicists' concept of the continuity of matter and energy, and in the efforts of philosophers.

Having lived and worked through this period of change, some of us shared the growing restiveness of medicine with its own successes. One could see as well its pressing needs. Moreover, Claude Bernard's brilliant definition of disease as resulting from attempts at adaptation deals with primitive biologic levels of reaction. Whereas these hold for man, disease in man has a more complex meaning, since his attempts at adaptation involve a highly developed nervous system. With his elaborate brain he is so constituted that he reacts not only to actual assault but to threats and symbols of danger experienced in his past which call forth reactions like those to assault. Also, man's special relation to man introduces another set of factors. Hence, backed by long bedside experience and the realization that much of medicine is the understanding of human motivation, physicians in scattered centers throughout the world turned their energies into studies of man in his context and the pertinence of this relationship to disease. Enthusiastic about the new wave of interest in purpose and goal, they became convinced that the scientific method was suitable for such study and could be applied. They were challenged by the opportunity, on the one hand, of keeping medicine compassionate, and, on the other, of making it even more scientific and dynamic.

It is noteworthy that naturalists, and more particularly zoologists have long, by preference and training and with delight and profit, observed living creatures in their context, attempting to understand their goal directed behavior. This preference of the naturalists and their point of view is appraised amusingly by the Spanish physiologist, Suner: While physiologists, says he, built their science by means of designed experiments, biologists built theirs by observing the experiments of Nature. Designed experiment divides phenomena into small sections of space and time. Naturalists, on the contrary, freely observe the course of life on a big scale.

Thus, looking at living creatures in their environment, naturalists have described what have been called "displacement patterns," by which they mean the performance of a behavior pattern in biologically inappropriate circumstances, when an appropriate action is blocked. The behavior does not directly serve the survival of the individual or the species. Biologically, it is irrelevant to the situation in which it is performed. For example, a wild rat feeding, disturbed by another rat of a different species, makes aggressive noises and motions toward the interloper. The latter flees. The first rat then, instead of immediately resuming feeding, briefly grooms its face with its forepaws, an action which it would not ordinarily perform in the middle of feeding. Deprived of the object of its aggression, the first rat resorts to an alternative and inappropriate behavior pattern.

Another example: If an animal has open to it two conflicting patterns of action, it may do something else, which is entirely inappropriate. Thus, a herring gull in a situation calling for either attack or running away, neither of which it can carry out, may resort to grass pulling . . . a completely inappropriate action. Or, a third example: gulls have

been studied during the period of sitting on their eggs. If one egg is removed from the nest, the gull starts completely inappropriate nest-building movements. When more eggs are removed the nest-building movements increase and the number of such movements in a given time increases in proportion to the number of eggs removed. Preening increases markedly when all the eggs are removed. This affords a splendid example of the quantitative expression of displacement behavior.

I would now invite you to see man, his behavior and his diseases as would a naturalist — one who delights in observing living creatures in their context and attempts to understand their goal directed behavior.

We may then ask, do men exhibit such inappropriate responses or displacement behavior as the rat or the gull? Can his organs and functions be so disordered during inappropriate responses as to give rise to pain, be relevant to disease or even survival? The answer is, yes.

Over the years one organ or system of organs after the other has been studied in man functioning in his context. It has been shown, for example, that in a setting perceived by an individual as presenting a certain type of threat, the mucous membrane lining of the stomach becomes intensely engorged, its acid secretion greatly accelerated, and its rhythmic contractions augmented. This is the stomach pattern of a man preparing to eat a meal. Under circumstances that call for entirely different reactions of aggression or striking in anger, the individual inappropriately evokes an eating pattern! Obviously, since the eating pattern cannot resolve the situation that evoked it, it is excessively prolonged and peptic ulceration may ensue.

In kindred studies of the large bowel it has been observed that in those who perceive themselves as threatened in a given way, great quantities of blood engorge the mucous membranes and motility and secretion are increased. This is the pattern of ejection — one that could be used in ridding the organism of materials inadvertently taken in, yet it is used inappropriately to help the man rid himself of an unattractive human problem that cannot be dealt with this way. Abnormal secretions and break-down by-products may then destroy the lining of the bowel, resulting in ulcerative colitis.

Studies of the mucous membranes, of the nose upper airways and lungs have shown that circumstances perceived by an individual as threatening may result in engorgement of the mucosae, increase in secretion of mucous and protective cells with contraction of smooth muscle of the airways and even spasm of skeletal muscle. The eyes may tear and close. This is the pattern evoked by dangerous gases, fumes, dust, and micro-organisms and serves to shut out, neutralize, and wash them away. Yet it is used by the subject in dealing with an offensive man-to-man situation. The result may be, because of excessive and inappropriate use, chronic infection, chronic obstructive disease and asthma. Alterations in the chemical make-up of the secretions within the lungs may end in tuberculosis by affording an opportunity for organisms to reproduce that otherwise would die.

Under circumstances that threaten an individual's fulfillment of his role as a man, the blood vessels about the head may dilate painfully and the great sheets of muscle of the head and neck may go into cramp.

Many skin disorders arise under threatening circumstances because of inappro-

priate responses of the blood vessels and unusual secretions in the skin. Under like conditions, the kidney may be damaged because it gets too little blood, with great outpouring, or retention of water and salt. So also may the heart and blood vessels of the body overwork and excessively contract as though a man were facing a crisis of fight or flight, or stopping a mortal hemorrhage, when, indeed, he may be sitting quietly in his office chair.

When a person sees his prestige endangered, the glands of internal secretion — the pituitary, the thyroid, and the adrenal glands — may respond as though his very existence were in jeopardy, as by starvation, or by the sudden unusual demands of very low temperature, or violent action.

Contraction of the muscles of the extremities and back, inappropriately responding to threatening circumstances by preparing the individual for prompt action that never takes place, may cause cramps and aches.

Even the master organ, the brain, shares in such evil effects. Thus, infants and children in a hostile atmosphere may not mature, and indeed, may act as idiots. And men exposed to the prolonged abuse of hatred of their fellows as in prison, behave as though their heretofore actively functioning brains were severely damaged. Complete isolation, lack of opportunity to talk, repeated failure, and frustration, being reviled by his fellows, makes a man confabulate, become more suggestible, and rationalize his own unacceptable behavior. He may abandon a value system for one utterly incompatible with his former principles. In short, the effects of prolonged adversity on brain function may be difficult to distinguish from the results of actual destruction of brain.

And so, no organ or part of the body is spared during these inappropriate responses so suggestive of the displacement behavior pattern of the rat and the gull. The general inference is that during the process of adaptation a threatened individual uses inappropriately and for prolonged periods, functions and parts that cannot help him to make this adaptation. Since the situation cannot be resolved in this way, the organ or part may be damaged and sometimes even jeopardize a man's life.

Rapid and violent social change may also be a serious threat. Nearly twenty-five centuries ago Hippocrates reminded his contemporaries of the risk of such changes when he said, "Those things which one has been accustomed to for a long time, although worse than things which one is not accustomed to, usually give less disturbance."

An amusing observation relevant to the effects of change was made on Hopi Indians. The young Hopi, American schooled, may be contrasted with his father. His father believed that when he trod on the track of a snake, he would get sore ankles unless he took himself to the medicine man, who by incantation could prevent this. This he believed without question, and by acting so, his ankles were not sore. In contrast, his American-schooled son, no longer believing in the powers of the medicine man (considering him a humbug), nonetheless gets sore ankles after walking in the track of a snake. The implication is clear. In a rapidly changing society, anxiety-inducing factors outlive anxiety-resolving factors.

Is there evidence that these disruptive changes may be relevant to disease? Is it fortuitous that in a given society mortality from tuberculosis reaches its peak

within ten to twenty years after industrialization and thereafter falls off rapidly? Is it meaningless that when populations are moved, trouble ensues? When a sizable block of Ireland's population emigrated to American seacoast cities they were better fed, had more opportunities for work, were titillated by many novel experiences, and had more promise for the future. Yet, the death rate from tuberculosis among the Irish in New York City, for instance, was one hundred per cent greater than at the same time in Dublin.

Is it an accident that far greater numbers of American Indians died from tuberculosis when they were moved from the plains to reservations in miles not very far distant? Or that tuberculosis killed hordes of Bantu natives, moved from the country outside of Johannesburg into the environs of the city? Some of them, told that they were about to die, asked to be sent back to their Kraals. Many died, a few survived, but tuberculosis was widely spread by them in the native villages. Interestingly enough, deaths from tuberculosis did not vastly increase with such spread, suggesting that the Bantus in their native environment could deal better with the infection.

Again we ask, is it without larger significance that the incidence of hyperthyroidism in Norway increased one hundred per cent during the first year of World War II when that country was invaded? Is there nothing to be learned from the fact that periods of great duress bring about the decline of some diseases while others increase? Thus, successful Dutch merchants who had peptic ulcers before incarceration in German concentration camps lost their stomach lesions under the horrendous conditions that augmented other diseases. (Sadly, I add, many regained their peptic ulcers upon returning to Main Street.)

Recently answers to some of these questions have been sought. A large scale study of men and women in the context of their environment, and its pertinence to their health, has been made by a group working in the Human Ecology Program at The New York Hospital-Cornell Medical Center. In this research the life stories of approximately 3,500 ostensibly healthy people were analyzed. These included not only Americans, but also an homogenous group of foreign-born persons with an entirely different cultural tradition. Several striking generalizations came from these studies.

Illness was not spread evenly throughout the population. Indeed, about one quarter of the individuals account for more than one-half the episodes of illness. There were more than 20 times as many episodes of illness in the least healthy members of the group as compared to the healthy members. Thus, some individuals had as little as 10 days of absence from work because of illness in 20 years, and others more than 1300 days in the same length of time.

The persons with the most illness also had the widest variety of illnesses. To be emphasized is that illness included all categories not only major and minor, but medical, surgical and psychiatric diseases, including infections, injuries, and new growths.

The episodes of illness clustered, that is, there were many episodes occurring in one or more particular years, contiguous with other periods during which few or no illnesses occurred. For example, a given man during his earlier life had at the same time disorders of respiration and digestion, and a serious infectious disease. A later cluster of illnesses in the

same person included disorders of the liver, the heart, the glands of internal secretion and of respiration. In both clusters he showed disorders of mood, thought and behavior. The clusters of illnesses of all sorts predictably occurred during those periods of life perceived by the subject as stressful. No satisfactory adaptation to meet these situations was worked out, and inappropriate patterns of response were used.

On the other hand, the well person was one who felt able to handle the demands of his environment, was stimulated by hindrances and whose conflicts and feelings of guilt were not sustained unduly. Change as it arose was dealt with directly. The same was true of the sick individual during his better periods.

What reference have these points to survival or to death? Our study is still too young to answer this question. But there are hints from other sources that years of life can be pressed out of man by catastrophe or prolonged duress. Most physicians have seen sudden and unexplainable death come to those who are overwhelmed or filled with despair. There is good evidence that "bone pointing," "hexing," and excommunication of transgressors of tribal mores may remarkably shorten life if not immediately kill a man. Suitable studies have not been made until now to explain such deaths. However, it has been shown that wild rats capable of swimming 90 or more hours, may, nevertheless, when terrified and then plunged into water, die in a few minutes. Careful study of the heart in these creatures revealed that death resulted from a depressive action of the nervous system, gradually slowing and ultimately arresting the heart's beat. Moreover, if lifted out of the water just before the heart stops the rat promptly recovers, and on subsequent immersion swims as it did before its crisis.

Early information from Japan, as yet statistically unsupported, indicates that those who experienced the catastrophe of the atom bomb at Hiroshima, but who suffered no burns or direct effects of irradiation, have had a shorter life span than other Japanese. Death has resulted from the usual and varied terminal illnesses. It is as though they had grown 20 years older than their age. Though we lack definitive support for this early impression, we do have precise information from our own records of the War, concerning the effect on life span and health of prolonged adverse life experience.

Thus, of approximately 6,000 United States prisoners of war captured by the North Koreans, about one-third died. Medical observers reported that the cause of death in many instances was ill defined, and was referred to by them as "give-up-itis." Occurring as it did in a setting of serious demoralization, humiliation, despair and deprivation of human support and affection, the prisoner became apathetic, listless, neither ate nor drank, helped himself in no way, stared into space and finally died.

A recently completed study of the effects of imprisonment on Americans during World War II tells us that approximately 94,000 United States prisoners of war were taken in Europe. These men were imprisoned about ten months. Less than one per cent of them died before liberation. In contrast, in the Pacific theater, about 25,000 Americans became prisoners of war. They remained in prison four times as long as those captured in Europe, and suffered far more than any others the effects of threats, abuse and humiliation. Their demoralization

was often extreme. Over one third died before liberation.

Six years after liberation, those that survived the Japanese prison experience were re-examined. In the first place the total number of deaths in this group during these six years was more than twice the expected incidence for a similar groups of persons not so exposed, and three times as great as in the group of United States Prisoners of war in Europe. The causes of death included many diseases not directly related to confinement or starvation. Thus, twice the expected number died of heart disease, more then twice the expected number of cancer, more than four times the expected number died of diseases of the gastrointestinal tract. Twice the number from suicide, and most striking of all, three times the expected number died as a result of accidents. Nine times the expected number died of pulmonary tuberculosis.

What happened to those that survived? What was the incidence of illness during the six years after their liberation? It was found that the admission rate to veterans' hospitals of the former prisoners of war of the Japanese was closely related to the amount of stress endured by the former soldier during his imprisonment. Those who had experienced less duress had admission rates only slightly more than the European prisoners of war, whereas, those who had suffered greatly had far the greatest number of admissions, amounting to seven times as many as did those who had not been prisoners, and "very poor health" interfered with work in one half. Interestingly enough, as in the group of 3,500 persons studied in the previously cited Human Ecology Program, those that were in "very poor health" had many different diseases, including those that did not appear to be immediately related to incarceration, i.e., hernia, deafness, and diseases of bones, muscles and heart. There were ten times as many "impairments" as among the European prisoners of war group.

What about the rest who neither died nor became sick or disabled? Again facts run out. But a study of a few of the survivors who have since become unusually effective citizens is suggestive. Despite exposure to many stressful conditions, the imprisonment for them was a painful but temporary interruption in a life viewed as a continuum. They were convinced that they would come out alive and that they would not be imprisoned long. They were able to extract a few satisfactions even while enduring deprivations. New interests were cultivated (one man raised rabbits for food and began breeding them for increased size). But mind and spirit were mainly focused on life as it was to be lived in to the future. The immediate distress seemed less real; the future more substantial. Plans were made for occupation, marriage, family, children, often with meticulous and obsessive detail, including domicile, city or town, education for self and kin, entertainment, the kind of food and where it would be eaten. Among these prisoners academic courses were organized, teaching carried out, seminars and discussions led. These men formed tight knit groups, believed in, helped each other, and even laughed together.

Immediately after liberation, a few had transient illnesses, but there is little to indicate that their vitality has been sapped. Indeed, a few have assumed major responsibilities.

In short, prolonged circumstances which are perceived as dangerous, as

lonely, as hopeless, may drain a man of hope and of his health; but he is capable of enduring incredible burdens when he has self-esteem, hope, purpose, and belief in his fellows.

Now to return to our question — Has disease meaning? If the data have been presented clearly, it should be evident that disease is closely linked with efforts at adaptation. On a simple biologic level, disease can mean that attempts at adaptation have over or undershot the mark. On the level of man's elaborate nervous equipment, responses which result in disease may be inappropriate in kind as well as in amount.

Man meets threats, assaults and crises and as well strives to fulfill his potential, using his faulty adaptive patterns. He may find that many ends are more important than comfort, a few, more important than health or even than personal survival. It is well, however, that we examine our means of attaining those ends, and that we know as far as we can the price of our values.

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patient care

(Continued from page 4)

with the head nurse. Any problems will be brought to the attention of the patient's doctor and to other health team members, such as the public health nurse (a specialist in home nursing care) or the medical social worker. The patient's daughter and son-in-law, with whom he lives, will be interviewed during visiting hours. Were Mr. W's problems purely nursing problems they would be resolved by the nursing team. When they extend beyond that area, the nursing team receives direction and help from other professionals on the hospital staff.

Throughout the day the team leader assists and supervises her team and is available for on-the-spot decisions. In effect she is giving highly personalized care to more patients than she alone could possibly care for. Each nursing coworker understands what is to be done for her patients and why, and each is satisfied that she is giving them the best possible care.

Nursing teams have become a highly effective means of providing the more intensive patient care which is required today. Basically the team is an extension of the professional graduate nurse, an extension made necessary by the present shortage of nurses.

The use of such teams means a new kind of patient care—patient care which is highly organized but very personal. The patient is recognized as an individual, and his welfare is the concern of a group of health practitioners working toward common ends. The team method of assignment now makes it possible to look beyond the limited "recovery" of yesterday, toward the unlimited return to health and usefulness of today.

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